

Registration District No.

318

Primary Registration District No

1003

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County St. Louis  
(c) City or town Lemay  
(If outside city or town limits, write "RURAL")  
(d) Street No. 329 Goetz ave.  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (b) If veteran,  
name war.....No

3. (c) Social Security No. 192-10-3362

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Adele Ludwig

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased June 23 1888  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<del>68</del>	60	2	11	hr. min.

9. Birthplace St. Charles Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation.....Retired

11. Industry or business

12. Name George Ludwig

13. Birthplace.....Germany 4  
(City, town, or county).....(State or foreign country)

14. Maiden name Louise Taylor

15. Birthplace St. Charles Mo.  
(City, town, or county) (State or foreign country)

16 (c) Informant Mrs. Adele Ludwig

10. (a) Informant \_\_\_\_\_  
(b) Address 329 Goetz ave.

13. (c)	Burial	(b) Date thereof	Sept. 8, 1948
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17. (a) \_\_\_\_\_ (Burial, cremation, or removal) \_\_\_\_\_ (Month) (Day) (Year)  
(c) Place: burial or cremation **Mt. Hope Cemetery**

18. (c) Signature of funeral director C. Hoffmeister U. & L. Co.

(b) Address: 7814 S. Broadway

19. (a) SEP 7 1948 (b)  
(Data received local registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9-4-48 day 7:15 P.M.  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M \_\_\_\_\_

21. I hereby certify that I attended the deceased from 7-19-48 to 9-4-48  
Im, 1948 to 1948  
 that I last saw him alive on 9-4-48  
 and that death occurred on the date and hour stated above.

Immediate cause of death. <u>Cerebral</u>	Duration
<u>Vascular Thrombosis</u>	

Due to Arteriosclerotic Heart Disease Uncert

Due to \_\_\_\_\_

Other conditions.....  
(Include pregnancy within 3 months of death)

### Major findings:

Of operation

- Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

(c) Where did injury occur?.....  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work \_\_\_\_\_ (Specify type of place) \_\_\_\_\_  
(c) Means of injury \_\_\_\_\_

Signature J.C. Pharma Int. (M.D. or other)  
Address 1325 Grand Bl. Date signed 9-5-4

(Licensed Embalmer's Statement on Reverse Side)

**WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD**

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

working under my personal supervision. \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_

**Signed.**

~~Licensed Embalmer No~~

P. O. Address

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**